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EDITORIAL

Physician Assisted Suicide in Europe: Some Lessons and Trends

The primary focus of this special issue of *European Journal of Health Law* is Physician Assisted Suicide (PAS). The four principal papers offer perspectives on the current state of play and reform proposals in Belgium, Germany, Switzerland and the United Kingdom. In doing so, they also reveal common themes across each of these jurisdictions; themes which recur anywhere where debate takes place on the acceptability of PAS, and on the role of the law in regulating the practice, or not, as the case may be.

The starting point is invariably the criminal law and its stance on assisted suicide. While this is illegal in the United Kingdom, for example, it is not so in Belgium. Neither country has as yet legislated specifically on PAS, presumably content with their respective positions. Those positions are, of course, potentially diametrically opposed. Thus, in the United Kingdom a health care professional (HCP) who assists a patient to die will be as liable to criminal prosecution as anyone else who aids or abets suicide (a position which ignores the acute ethical dilemmas for HCPs when faced with requests to die), while in Belgium it has been suggested that perhaps legal intervention in such an ethically-charged domain is inappropriate and that the status quo should remain, leaving HCPs to act unencumbered by the threat of criminal charge. But the irony in Belgium, as discussed by Nys in his contribution, is that the country has already legislated in the far more controversial field of active euthanasia.[1] Moreover, given that for many the ethical and legal issues surrounding euthanasia and PAS are indistinguishable, it is indeed curious that Belgium would not have availed herself of the opportunity to bring PAS within a regulatory regime.

Nys's explanation for this (deliberate) omission brings us, to my mind, to what is the issue at the heart of the debate on PAS (and, indeed, all forms of euthanasia). Nys suggests that little more than political expediency led to the exclusion of PAS from Belgium's reforming measures. This was as a reaction to the characterisation of PAS which took hold at the time when the legislation was being debated. That characterisation cast PAS as a 'death on demand' measure which reduced the debate to an extremist view of PAS as killing someone simply because it was their 'choice' – with little else in the way control or regulation. The Belgian government,

keen to distance itself from such an extremist view, did not then pursue any reforms in respect of PAS.

While polarisation of the debate is sadly the order of the day in so many discussions in this field, this is a valuable and telling interpretation of the Belgian experience. It speaks to the role and influence of the key feature of so much health law policy today, namely, the autonomy of the individual. The right to choose the mode, manner and timing of one's own death is often held up as one of the most fundamental expressions of autonomy that a person can exercise, necessitating the recognition of such a right among the plethora of rights that most patients currently enjoy in Europe. Certainly, the autonomy argument has been successful in almost every other area of medical law in shifting the dynamics of the dr/patient relationship, and the regulation of medicine generally, more in favour of the patient and what she wants. But the Belgian example suggests that the reforms may well have been victim to unreconstructed, extremist conceptions of autonomy which presented patient choice and legal regulation as mutually exclusive matters; as if the former was determinative of the legality and appropriateness of acts designed to assist death. The legality of any course of action may depend on any number of things, and the consent of the patient can figure among them. But regulation of that conduct is different; legality is a threshold issue, while regulation ensures continued control of the practice being regulated, protection of both the instant patient and others, a means to monitor activities, and a mechanism to respond more effectively to abuses, should they occur. These are issues which reach far beyond the particular needs of any one individual; they point to the need in all of this debate to resist over-zealous reliance on autonomy-driven arguments to support PAS or other euthanistic practices. It also means that even if we are persuaded by the strength of autonomy arguments, these must still be considered in light of other considerations.

This was precisely the issue before the European Court of Human Rights (ECtHR) in *Pretty v United Kingdom*,[2] discussed by Biggs in her article in this volume. Dianne Pretty was mentally competent, sought assistance in dying to avoid an undignified demise through the natural process of her terminal illness, but was physically incapable of taking her own life. Her plea for help was rejected by the House of Lords and she sought final appeal to the Strasbourg Court. That Court engaged in the exercise described above, namely, considering the individual rights of the claimant as well as broader issues that might be prayed in aid of the British legal position which outlawed assisted suicide. Thus, the Court had no trouble upholding Mrs Pretty's claim that her choice to die and to seek assistance in the exercise of that choice invoked her right to respect for private life under Article 8(1) of the European Convention on Human Rights (ECHR). Notwithstanding, the British government was able to justify its position by relying on Article 8(2) of the Convention, most particularly referring to its obligation to protect other

vulnerable persons who might suffer if the legal regime were to change. In this way, the ECtHR revealed the fundamental tension in this field: while we might sympathise with each individual who is suffering and requests to die, can we be sure of establishing a regulatory framework that will respect their wishes while protecting the interests of those who have not, and cannot, express any such wish? Some may go further still and argue that autonomy has reached its limits in this context and that more fundamental societal values will be compromised if we seek to establish a legal regime which disrespects life itself. Moreover, the possibility of ever creating a regulatory framework which can maintain a clear line between the competent and the vulnerable is similarly, often, questioned.[3]

Biggs is not of this mindset. In her discussion of a Bill currently before a Select Committee of the British House of Lords she argues that a workable model is possible and she finds much merit in the instant proposal. It is interesting to note, however, that the proposal itself blurs another fine line in this field, namely, that between PAS and other forms of euthanasia, especially active euthanasia. As Biggs notes of the Bill, '…in some exceptional circumstances where a patient is not physically able to self-administer medication due to the nature of their illness, active assistance from a willing physician will be possible.'[4] This is presumably designed to assist someone who finds herself in tragic circumstances similar to Dianne Pretty, and this is admirable as far as it goes. But I would wager that this will also prove to be a particularly problematic aspect of the Bill given the penchant for politicians to be seen to resist staunchly the spectre of active euthanasia, however illogical or unsustainable the supposed distinction might be.

The papers by Becker-Schwarze and Guillod & Schmidt on the positions in Germany and Switzerland respectively point to the definitional difficulties in attempting to differentiate clearly between different kinds of activity in respect of causing death, assisting death, or allowing death to be caused. Becker-Schwartze's contribution is particularly interesting for its treatment of the German position on the duty to rescue – a common civil and criminal law feature in many continental European jurisdictions – but one which has complicated the debate on PAS in Germany. From a communitarian perspective one might view such provisions as a useful counterbalance to autonomy-based claims that postulate a 'right to die' or, at least, a right to be assisted in dying. For, such measures emphasise that – as members of a collective – we owe obligations to each other, some of which require us to act (for example the duty to rescue), and others which require us to refrain from action. On this last point, it might be argued, for example, that the decision to commit suicide is not merely self-regarding; it impacts significantly on those around us and on society as a whole; we may, indeed, owe duties to others not to take our own life. But the recent jurisprudence and literature in Germany reveal more of a tendency to view duty of rescue provisions as a denial of individual rights. While the case-law remains in a state of flux, the overall

drift seems to be towards the autonomy path. Certainly, the recent recommendations of the Ministry of Justice Working Group entitled 'Patient Autonomy at the End of Life' leaves the reader in little doubt as to the nature of its recommendations which are likely to be heavily influential in the formation of German policy in the future.

Guillod & Schmidt's discussion of the facilitative regime of PAS in Switzerland brings all of these themes nicely together. They point out that the 'cultural sensitivity' of a nation is reflected in the language of its law, and while euthanasia is eschewed as a legal term of art in Switzerland, proposals on the question of decriminalising assisted suicide have been on the table since 1918, and have formed part of Swiss law since 1942. The crucially important feature of the law is the motive of the person who assists. Thus, so long as the assistance is a selfless act – that is, there is no selfish motive – then no criminal liability will flow from a successful assisted suicide. This is not specific to the medical profession and even extends, theoretically, to assistance borne out of indifference. The position is different for mercy killing, however, where the absence of a 'suicide' means that direct assistance to die remains subject to prosecution. This brings us back once again to the state of the criminal law, which, as a crude tool, tends only to tell us about legality or illegality. Until recently, this was as far as the Swiss position had reached. Most recently, however, the Swiss National Advisory Committee on Biomedical Ethics has supported the status quo – that is, that assisted suicide is not illegal – but has added the important proviso that regulation be introduced in respect of institutions who undertake to assist someone in their suicide. Moreover, there is no suggestion of introducing residency requirements, meaning that the current trickle of terminally ill patients into Switzerland from less liberal countries in search of their Last Hope of a peaceful death may grow substantially in future years if other jurisdictions continue to vacillate.

Illegality is, of course, also a form of regulation, but as evidence from the UK demonstrates in Biggs' article, it can be a singularly ineffective approach.[5] There is no doubt that attitudes towards assisted death have changed, and are changing, around Europe. Each of the articles in this issue offers numerous examples of proposals for reform over the last few decades. Few, however, succeeded. A similar story is repeated around the continent. What, then, are we to make of a plethora of (failed) reforms? Do we focus on their sheer number as a mark of where we are going, or do we take their failure as an indication of continued resistance to the very idea of physician assisted suicide? Only time will tell.

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Notes:

1. Act on Euthanasia of 28th May 2002.
2. *Pretty v United Kingdom* [2002] ECHR 423.
3. See J Keown, *Euthanasia, Ethics and Public Policy*, Cambridge University Press, 2002.
4. S1(2) of the Assisted Dying for the Terminally Ill Bill 2004.
5. Much the same can be said of anti-abortion measures.